

**GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009**

S

D

SENATE DRS55104-LN-10A (12/18)

Short Title: State Hlth Plan \$/Good Health Initiatives.

(Public)

Sponsors: Senator Rand.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE STATE HEALTH PLAN FOR TEACHERS
AND STATE EMPLOYEES AND TO MAKE OTHER CHANGES RELATED TO THE
STATE HEALTH PLAN.

Whereas, the General Assembly must act quickly and prudently to maintain a financially stable State Health Plan to ensure that all members of the Plan have affordable access to medically necessary health benefits and services within available resources; and

Whereas, in order to meet current fiscal obligations the General Assembly must appropriate \$250,000,000 for the 2008-2009 fiscal year to cover the current year shortfall in funds; and

Whereas, estimates indicate that a substantially larger appropriation will be necessary to maintain the fiscal integrity of the Plan in the next and ensuing fiscal periods; and

Whereas, in order to ensure continued access to medically necessary health care to Plan members, the Plan must implement measures to contain costs through premium increases, benefit changes, and healthy lifestyle programs that not only reduce costs but improve member health; and

Whereas, the Plan estimates that over 70,000 Plan members use tobacco, resulting in a cost to the Plan of \$2,000 per member per year more than the cost of providing coverage for nonusers of tobacco; and

Whereas, over 60% of North Carolina adults are obese or overweight; and

Whereas, obesity is linked to an over 37% increase in health care spending at a cost of \$732.00 per member per year; and

Whereas, weight management and cessation of tobacco use have been demonstrated to result in improved member health and substantial savings in health care costs making it fiscally prudent to implement smoking cessation and weight management incentives and initiatives with mechanisms to verify member compliance with smoking cessation and weight management requirements; Now, therefore,

The General Assembly of North Carolina enacts:

PART ONE: APPROPRIATIONS, DEFINITIONS, AND SCOPE.

SECTION 1.(a) Appropriation for 2008-2009 fiscal year. – There is appropriated from the Savings Reserve Account established in G.S. 143C-4-2 to the Health Benefit Reserve Fund established in G.S. 135-44.5 the sum of two hundred fifty million dollars (\$250,000,000) for the 2008-2009 fiscal year. These funds shall be used to address the shortfall in funds



* D R S 5 5 1 0 4 - L N - 1 0 A *

1 available for the payment of hospital and medical benefits and administrative costs under the
2 State Health Plan for Teachers and State Employees ("Plan") for the 2008-2009 fiscal year.

3 **SECTION 1.(b)** General Fund appropriation for 2009-2011 fiscal biennium. –
4 Notwithstanding G.S. 143C-5-2, there is appropriated from the General Fund to the Reserve for
5 State Health Plan in the Office of State Budget and Management the sum of one hundred eight
6 million four hundred thirty-two thousand four hundred twenty-five dollars (\$108,432,425) for
7 the 2009-2010 fiscal year and the sum of two hundred twenty-four million seven hundred
8 sixty-eight thousand sixty-seven dollars (\$224,768,067) for the 2010-2011 fiscal year. These
9 funds shall be used to cover health care and administrative costs to the Plan in the 2009-2011
10 fiscal biennium.

11 **SECTION 1.(c)** Highway Fund appropriation for the 2009-2011 fiscal biennium.
12 Notwithstanding G.S. 143C-5-2, there is appropriated from the Highway Fund to the Reserve
13 for the State Health Plan in the Office of State Budget and Management the sum of five million
14 sixty thousand one hundred eighty dollars (\$5,060,180) for the 2009-2010 fiscal year and the
15 sum of ten million four hundred eighty-nine thousand one hundred seventy-six dollars
16 (\$10,489,176) for the 2010-2011 fiscal year. These funds shall be used to cover health care
17 and administrative costs to the Plan in the 2009-2011 fiscal biennium.

18 **SECTION 1.(d)** All other agency funds required to fund the premium increase
19 enacted in this act, other than funds appropriated in subsections (b) and (c) of this section, are
20 appropriated for the 2009-2011 fiscal biennium.

21 **SECTION 1.(e)** Definitions. – As used in this act unless the context clearly
22 requires otherwise:

- 23 (1) "Plan." – The State Health Plan for Teachers and State Employees.
- 24 (2) "Basic plan." – The Plan's PPO option providing for 70/30 in-network
25 coverage after deductibles and co-payments.
- 26 (3) "Smoking" or "Smoking cessation." – Includes cessation of the use of all
27 tobacco products.
- 28 (4) "Standard plan." – The Plan's PPO option providing for 80/20 in-network
29 coverage after deductibles and co-payments.

30 **SECTION 1.(f)** Scope. – In the event of a conflict between the provisions of this
31 act and Article 3A of Chapter 135 of the General Statutes, this act prevails.

32 **PART TWO: HEALTH BENEFIT CHANGES.**

33 **SECTION 2.(a)** Eliminate PPO Plus Option. – Effective July 1, 2009, the PPO
34 Plus option (90/10 in-network coverage) under the State Health Plan for Teachers and State
35 Employees ("Plan") is eliminated. The Executive Administrator shall provide notice to all
36 members of the Plan that this option will no longer be available as of July 1, 2009. Employees
37 enrolled in the Plan's Plus option shall have the choice of enrolling in the Basic or Standard
38 plan options for the 2009-2010 benefit year.

39 **SECTION 2.(b)** Implement Comprehensive Wellness Initiative.

- 40 (1) Program development. – The Plan shall develop a Comprehensive Wellness
41 Initiative that includes a focus on smoking cessation and weight
42 management and that is designed to be implemented effective July 1, 2010,
43 for smoking cessation and July 1, 2011, for weight management. Benefit
44 levels shall be determined by the Plan based upon tobacco use or the
45 inability of the member to meet national, evidence-based healthy weight
46 clinical guidelines. For purposes of the Comprehensive Wellness Initiative,
47 "member" includes all State Health Plan primary subscribers and their
48 covered dependents. The Plan shall develop a process whereby a Plan
49 member may appeal the Plan's basis for action it takes due to the member's
50 failure or refusal to comply with the Plan's smoking cessation or weight
51 management requirements.

1 (2) Smoking cessation. – Effective July 1, 2010, all members of the Plan who do
2 not have Medicare as their primary coverage shall be enrolled in the Basic
3 Plan under the Plan's PPO unless the subscriber can attest that the subscriber
4 or any qualifying dependent does not smoke or otherwise use tobacco
5 products. The Plan shall develop a mechanism for verifying that the member
6 does not smoke or use other tobacco products. Tobacco use will be
7 reassessed annually at the time of Plan enrollment. All subscribers who have
8 attested that neither they nor their dependents use tobacco, or whose medical
9 provider certifies in writing that the member is participating in a smoking
10 cessation program, shall have the choice of remaining in the Basic plan
11 option or enrolling in the Standard plan option. For purposes of the smoking
12 cessation initiative, "member" includes all members covered under the Plan.
13 As used in this section, "smoking cessation program" means active
14 participation in a Plan-approved cessation program to include counseling or
15 use of tobacco cessation medications.

16 (3) Weight management. – Effective July 1, 2011, all members of the Plan who
17 do not have Medicare as their primary coverage shall be enrolled in the
18 Basic Plan under the Plan's PPO Plan unless the subscriber attests that the
19 weight and height of the member is within a range determined by the Plan
20 based on evidence-based healthy weight clinical guidelines, or unless the
21 member's medical provider certifies in writing that the member has a
22 medical condition that prevents the attainment of the specified weight range
23 and that the member is actively participating in a Plan-approved weight
24 management program. In either case, the member shall have the option to
25 enroll in the Basic or Standard plan.

26 Not later than October 1, 2009, the Executive Administrator shall inform Plan
27 members of the healthy lifestyle initiatives, requirements for compliance, and consequences of
28 noncompliance. The Executive Administrator shall provide to members education and training
29 to assist members in complying with healthy lifestyle initiatives. The Executive Administrator
30 may implement incentive initiatives to further encourage member achievement in smoking
31 cessation, weight management, and other integrated health management programs.

32 The Executive Administrator shall report to the Committee on Employee Hospital
33 and Medical Benefits recommendations the Plan may have for additional sanctions that may be
34 imposed when the Executive Administrator finds that a member intentionally makes a false
35 statement on a Plan document.

36 **SECTION 2.(c)** Prescription drug co-payments. – G.S. 135-45.6(b) reads as
37 rewritten:

38 "(b) Prescription Drugs. – The Plan's allowable charges for prescription legend drugs to
39 be used outside of a hospital or skilled nursing facility shall be as determined by the Plan's
40 Executive Administrator and Board of Trustees, which determinations are not subject to appeal
41 under Article 3 of Chapter 150B of the General Statutes. Co-payments and other allowable
42 charges or coverage for prescription drugs shall be as follows:

43 (1) The Plan will pay allowable charges for each outpatient prescription drug
44 less a copayment to be paid by each covered individual equal to the
45 following amounts: pharmacy charges up to ten dollars (\$10.00) for each
46 generic prescription, ~~thirty dollars (\$30.00)~~ thirty-five dollars (\$35.00) for
47 each preferred branded prescription without a generic equivalent, and forty
48 dollars (\$40.00) for each preferred branded prescription with a generic
49 equivalent drug, and fifty dollars (\$50.00) fifty-five dollars (\$55.00) for each
50 nonpreferred branded or generic prescription. For each preferred branded
51 prescription drug with a generic equivalent drug, the member shall pay the

1 generic co-payment plus the difference between the Plan's cost for the
2 generic prescription and the Plan's cost for the branded prescription drug.

3 (2) The Plan shall provide coverage of nonacute self-administered specialty
4 medications under the Plan's pharmacy benefit through a specialty pharmacy
5 vendor under contract with the Plan. The Plan may transfer coverage of
6 specified specialty disease medications covered under the Plan's medical
7 benefit to the contracted specialty pharmacy vendor. Specialty medications
8 are biotech medications or other medications that exceed five hundred
9 dollars (\$500.00) cost to the Plan per prescription. The Plan shall impose a
10 co-payment in the amount of twenty-five percent (25%) of the Plan's cost of
11 the specialty drug not to exceed one hundred dollars (\$100.00) per
12 prescription per 30-day supply.

13 (3) The Plan may exclude coverage of drugs that have therapeutic equivalents
14 that are available over the counter. Before excluding coverage under this
15 subdivision, the Plan shall consult with the Plan's Pharmacy and
16 Therapeutics Committee.

17 ~~These co-payments apply to all optional alternative plans available under the Plan.~~

18 (4) Allowable charges shall not be greater than a pharmacy's usual and
19 customary charge to the general public for a particular prescription.
20 Prescriptions shall be for no more than a ~~34-day~~30-day supply for the
21 purposes of the copayments paid by each covered individual. By accepting
22 the copayments and any remaining allowable charges provided by this
23 subsection, pharmacies shall not balance bill an individual covered by the
24 Plan. A prescription legend drug is defined as an article the label of which,
25 under the Federal Food, Drug, and Cosmetic Act, is required to bear the
26 legend: "Caution: Federal Law Prohibits Dispensing Without Prescription."
27 Such articles may not be sold to or purchased by the public without a
28 prescription order. Benefits are provided for insulin even though a
29 prescription is not required. ~~The Plan may use a pharmacy benefit manager~~
30 ~~to help manage the Plan's outpatient prescription drug coverage. In~~
31 ~~managing the Plan's outpatient prescription drug benefits, the Plan and its~~
32 ~~pharmacy benefit manager shall not provide coverage for sexual~~
33 ~~dysfunction, growth hormone, antiwrinkle, weight loss, and hair growth~~
34 ~~drugs unless such coverage is medically necessary to the health of the~~
35 ~~member. The Plan and its pharmacy benefit manager shall not provide~~
36 ~~coverage for growth hormone and weight loss drugs and antifungal drugs for~~
37 ~~the treatment of nail fungus and botulinum toxin without approval in~~
38 ~~advance by the pharmacy benefit manager. The Plan may adopt utilization~~
39 ~~management procedures for certain drugs, but in no event shall the Plan~~
40 ~~provide coverage for sexual dysfunction, hair growth, or drugs for cosmetic~~
41 ~~purposes that are not medically necessary. Any formulary used by the Plan's~~
42 ~~Executive Administrator and pharmacy benefit manager shall be an open~~
43 ~~formulary. Plan members shall not be assessed more than two thousand five~~
44 ~~hundred dollars (\$2,500) per person per fiscal year in copayments required~~
45 ~~by this subsection.~~

46 Co-payments authorized under this subsection apply to all optional alternative plans
47 available under the Plan."

48 **SECTION 2.(d)** Routine eye examinations not covered. – Effective January 1,
49 2010, G.S. 135-45.8(13) reads as rewritten:

50 **"§ 135-45.8. General limitations and exclusions.**

1 The following shall in no event be considered covered expenses nor will benefits described
2 in G.S. 135-45.6 through G.S. 135-45.11 be payable for:

3 ...

- 4 (13) Charges for routine eye examinations, eyeglasses or other corrective lenses
5 (except for cataract lenses certified as medically necessary for aphakia
6 persons) and hearing aids or examinations for the prescription or fitting
7 thereof."

8 **SECTION 2.(e)** Deductible and co-payment changes. – Effective July 1, 2009, the
9 Executive Administrator shall make the following changes to deductibles, coinsurance, and co-
10 payments under the Basic and Standard PPO plans:

11 (1) Basic plan (70/30):

- 12 a. Increase the in-network annual deductible to eight hundred dollars
13 (\$800.00) for member-only coverage and to one thousand six
14 hundred dollars (\$1,600) for the out-of-network annual deductible for
15 member-only coverage.

16 The aggregate maximum annual deductible for employee-child and
17 employee-family coverage shall be three times the member-only
18 annual deductibles.

- 19 b. Increase the in-network coinsurance maximum to three thousand two
20 hundred fifty dollars (\$3,250) for member-only coverage and to six
21 thousand five hundred dollars (\$6,500) for member-only
22 out-of-network maximum coinsurance. The aggregate maximum
23 coinsurance for employee-child and employee-family coverage shall
24 be three times the member-only coinsurance maximums.

- 25 c. Increase the in-network primary care co-payment to thirty dollars
26 (\$30.00) per covered individual.

- 27 d. Increase the in-network specialist co-payment to seventy dollars
28 (\$70.00) per covered individual.

- 29 e. Increase the in-network inpatient co-payment to two hundred fifty
30 dollars (\$250.00) per covered individual.

- 31 f. Increase prescription drug co-pays as required under
32 G.S. 135-45.6(b) as enacted by this act.

- 33 g. Except as otherwise provided in this act, out-of-network co-payments
34 for coverage not otherwise listed in this subdivision shall remain as
35 applicable in the 2008-2009 benefit year.

36 (2) Standard plan (80/20):

- 37 a. Increase the in-network annual deductible to six hundred dollars
38 (\$600.00) for member-only coverage and to one thousand two
39 hundred dollars (\$1,200) for the member-only out-of-network annual
40 deductible.

41 The aggregate maximum annual deductible for employee-child and
42 employee-family coverage shall be three times the member-only
43 annual deductibles.

- 44 b. Increase the in-network coinsurance maximum to two thousand
45 seven hundred fifty dollars (\$2,750) for member-only coverage and
46 to five thousand five hundred dollars (\$5,500) for member-only
47 out-of-network maximum coinsurance. The aggregate maximum
48 coinsurance for employee-child and employee-family coverage shall
49 be three times the member-only coinsurance maximums.

- 50 c. Increase the in-network urgent care co-payment to seventy-five
51 dollars (\$75.00) per covered individual.

- 1 d. Increase the in-network primary care co-payment to twenty-five
2 dollars (\$25.00) per covered individual.
3 e. Increase the in-network specialist co-payment to sixty dollars
4 (\$60.00) per covered individual.
5 f. Increase the in-network inpatient co-payment to two hundred dollars
6 (\$200.00) per covered individual.
7 g. Increase prescription drug co-pays as required under
8 G.S. 135-45.6(b) as enacted by this act.
9 h. Except as otherwise provided in this act, out-of-network co-payments
10 for coverage not otherwise listed in this subdivision shall remain as
11 applicable in the 2008-2009 benefit year.

12 **SECTION 2.(f)** Limitation on authority to change benefits. – G.S. 135-45(g) reads
13 as rewritten:

14 "(g) The Executive Administrator and Board of Trustees shall not change the Plan's
15 comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures,
16 and lifetime maximums in effect on ~~July 1, 2008~~, July 1, 2009, or a later act of the General
17 Assembly, that would result in a net increased cost to the Plan or in a reduction in benefits to
18 Plan members as a whole unless and until the proposed changes are directed to be made in an
19 act of the General Assembly."

20 **SECTION 2.(g)** Premium increases. – Premium rates for contributory coverage
21 established in accordance with G.S. 135-44.6 shall be increased to seven and three-tenths
22 percent (7.3%) for contributory coverage for the 2009-2010 fiscal year and shall be increased
23 by an additional seven and three-tenths percent (7.3%) over the premium rate for contributory
24 coverage for the 2010-2011 fiscal year.

25 **SECTION 2.(h)** Maintenance Medication Retail Pharmacy Network Initiative. –
26 The Plan shall implement a maintenance medication retail pharmacy network initiative that will
27 reduce pharmaceutical costs to the Plan and to members with respect to refills of long-term
28 maintenance drugs. Under this initiative, the Plan may establish a network of retail pharmacies
29 that agree to participate in the maintenance retail network. The Plan may require that after two
30 30-day refills of maintenance medications, members would be required to obtain maintenance
31 medications from a pharmacy in the maintenance retail network or by mail order. If the
32 member purchases the drug from any other source, the member shall be required to pay fifty
33 percent (50%) of the pharmacy allowable charges of the maintenance medication. For each
34 90-day supply of maintenance medications the member obtains from a pharmacy participating
35 in the maintenance retail network or by mail order, the member will be responsible for not
36 more than two and one-half times the monthly co-payment for a three-month supply for each
37 maintenance medication. This subsection does not apply to medications taken for acute
38 conditions or specialty medications.

39 **PART THREE: ELIGIBILITY CLARIFICATION.**

40 **SECTION 3.(a)** Dependent child clarifications. – G.S. 135-45.1(10) reads as
41 rewritten:

- 42 "(10) Dependent child. – A natural, legally adopted, or foster child or children of
43 the employee and or spouse, unmarried, up to the first of the month
44 following his or her 19th birthday, whether or not the child is living with the
45 employee, as long as the employee is legally responsible for such child's
46 maintenance and support. Dependent child also includes a stepchild of the
47 member who is married to the stepchild's natural parent. To be eligible, the
48 stepchild must have his or her primary residence with the member.
49 Dependent child shall also include any child under age 19 who has reached
50 his or her 18th birthday, provided the employee was legally responsible for
51 such child's maintenance and support on his or her 18th birthday. Dependent

1 children of firefighters, rescue squad workers, and members of the national
2 guard are subject to the same terms and conditions as are other dependent
3 children covered by this subdivision. Eligibility of dependent children is
4 subject to the requirements of G.S. 135-45.2(d). The Plan may require
5 documentation from the member confirming a child's eligibility to be
6 covered as the member's dependent."

7 **SECTION 3.(b)** Eligibility of full-time students. – G.S. 135-45.2(d) reads as
8 rewritten:

9 "(d) A foster child is covered as a dependent child (i) if living in a regular parent-child
10 relationship with the expectation that the employee will continue to rear the child into
11 adulthood, (ii) if at the time of enrollment, or at the time a foster child relationship is
12 established, whichever occurs first, the employee applies for coverage for such child and
13 submits evidence of a bona fide foster child relationship, identifying the foster child by name
14 and setting forth all relevant aspects of the relationship, (iii) if the claims processor accepts the
15 foster child as a participant through a separate written document identifying the foster child by
16 name and specifically recognizing the foster child relationship, and (iv) if at the time a claim is
17 incurred, the foster child relationship, as identified by the employee, continues to exist.
18 Children placed in a home by a welfare agency which obtains control of, and provides for
19 maintenance of the child, are not eligible participants.

20 Coverage of a dependent child may be extended beyond the 19th birthday under the
21 following conditions:

- 22 (1) If the dependent is a full-time student, aged 19 years and one month who has
23 attained the age of 19 by the end of the month following the student's 19th
24 birthday and through the end of the month following the student's 26th
25 birthday, who is pursuing a course of study that represents at least the
26 normal workload of a full-time student at a school or college accredited by
27 the state of jurisdiction. In accordance with applicable federal law, coverage
28 of a full-time student that loses full-time status due to illness may be
29 extended for one year from the effective date of the loss of full-time status
30 provided that the student was enrolled at the time of the onset of the illness.
31 (2) The dependent is physically or mentally incapacitated to the extent that he or
32 she is incapable of earning a living and (i) such handicap developed or began
33 to develop before the dependent's 19th birthday, or (ii) such handicap
34 developed or began to develop before the dependent's 26th birthday if the
35 dependent was covered by the Plan in accordance with G.S. 135-45.2(5)a."

36 **SECTION 3.(c)** Waiting periods subject to federal law. – G.S. 135-45.3(b) reads as
37 rewritten:

38 "(b) ~~Newly~~ Except as otherwise required by applicable federal law, newly acquired
39 dependents (spouse/child) enrolled within 30 days of becoming an eligible dependent will not
40 be subject to the 12-month waiting period for preexisting conditions. A dependent can become
41 qualified due to marriage, adoption, entering a foster child relationship, due to the divorce of a
42 dependent child or the death of the spouse of a dependent child, and at the beginning of each
43 legislative session (applies only to enrolled legislators). Effective date for newly acquired
44 dependents if application was made within the 30 days can be the first day of the following
45 month. Effective date for an adopted child can be date of adoption, or date of placement in the
46 adoptive parents' home, or the first of the month following the date of adoption or placement.
47 Firefighters, rescue squad workers, and members of the national guard, and their eligible
48 dependents, are subject to the same terms and conditions as are new employees and their
49 dependents covered by this subdivision. Enrollments in these circumstances must occur within
50 30 days of eligibility to enroll."

51 **SECTION 3.(d)** G.S. 135-45.4(b)(5) reads as rewritten:

1 "(5) To administer the 12-month waiting period for preexisting conditions under
2 this that Article, the Plan must give credit against the 12-month period for
3 the time a person was covered under a previous plan if the previous plan's
4 coverage was continuous to a date not more than 63 days before the effective
5 date of coverage. As used in this subdivision, a "previous plan" means any
6 policy, certificate, contract, or any other arrangement provided by any
7 accident and health insurer, any hospital or medical service corporation, any
8 health maintenance organization, any preferred provider organization, any
9 multiple employer welfare arrangement, any self-insured health benefit
10 arrangement, any governmental health benefit or health care plan or
11 program, or any other health benefit arrangement. Waiting periods for
12 preexisting conditions administered under this Article are subject to
13 applicable federal law."

14 **SECTION 3.(e)** Eligibility audit. – The Executive Administrator shall provide for
15 an audit of dependent eligibility under the Plan. The audit shall be designed to determine
16 whether all dependents currently covered under the Plan are eligible for coverage under current
17 law. Upon identification of an individual who is enrolled as a dependent but not eligible, the
18 Plan shall disenroll the ineligible dependent effective within 10 days of sending written
19 termination notice to the employee. The notice shall state the date upon which disenrollment
20 will become effective and the basis on which the determination of dependent ineligibility is
21 made. Notwithstanding any other provision of law, the Executive Administrator may waive
22 requirements to collect from the member reimbursement for claims paid for the ineligible
23 covered individual.

24 **SECTION 3.(f)** Cessation of coverage of ineligible individuals. – G.S. 135-45.12
25 is amended by adding the following new subsection to read:

26 "(k) The last day of the month in which a covered individual is found to be ineligible for
27 coverage."

28 **SECTION 3.(g)** Documentation of dependent eligibility. – G.S. 135-45.3 is
29 amended by adding the following new subsection to read:

30 "(c) When an eligible or enrolled member applies to enroll the member's eligible
31 dependent child or spouse, the member shall provide information as required by the Plan to
32 verify the dependent's eligibility for coverage."

33 **PART FOUR: NC HEALTH CHOICE CHANGES.**

34 **SECTION 4.(a)** Over-the-counter medications. – Coverage of over-the-counter
35 medication authorized under G.S. 108A-70.21(d) for the NC Health Choice Program shall
36 become effective on the later of July 1, 2010, or the date upon which the Department of Health
37 and Human Services assumes full responsibility for administration and processing of claims
38 under the NC Health Choice Program.

39 **SECTION 4.(b)** Subrogation. – For the period authorized under subsection (a) of
40 this section, the right of subrogation under G.S. 108A-57 applies to the State Health Plan for
41 payments made by the Plan under the NC Health Choice Program. This subsection expires on
42 the later of July 1, 2010, or the date upon which the Department of Health and Human Services
43 assumes full responsibility for administration, processing, and payment of claims under the NC
44 Health Choice Program.

45 **SECTION 4.(c)** DHHS Subrogation under NC Health Choice. – G.S. 108A-57 is
46 amended by adding the following new subsection to read:

47 "(c) This section applies to the administration of and claims payments made by the
48 Department of Health and Human Services under the NC Health Choice Program established
49 under Part 8 of this Article."

50 **PART FIVE: OTHER CHANGES.**

51 **SECTION 5.(a)** G.S. 135-45.4(b)(2) reads as rewritten:

1 "(2) Employees not enrolling or not adding dependents when first eligible may
2 enroll later on the first of any following month, but will be subject to a
3 twelve-month waiting period for preexisting conditions except as provided
4 in subdivision (a)(3) of this section. The waiting period under this
5 subdivision is subject to applicable federal law."

6 **SECTION 5.(b)** Utilization management functions. – G.S. 135-44.4 is amended by
7 adding the following new subdivisions to read:

8 "(13a) The Plan and its pharmacy benefit manager may implement and administer
9 pharmacy and medical utilization management programs and programs to
10 detect and address utilization abuse of benefits.

11 ...

12 "(29) For transplant and bariatric medical procedures, the Plan may restrict
13 coverage to certain in-network providers that are designated by the Plan's
14 claims processing contractor."

15 **SECTION 5.(c)** G.S. 135-44.1(b) reads as rewritten:

16 "(b) ~~Six~~ A majority of the members of the Board of Trustees in office shall constitute a
17 quorum. Decisions of the Board of Trustees shall be made by a majority vote of the Trustees
18 present, except as otherwise provided in this Part."

19 **SECTION 5.(d)** G.S. 135-45.9(b) reads as rewritten:

20 "(b) Notwithstanding any other provision of this Part, the following necessary services
21 for the care and treatment of chemical dependency and mental illness shall be covered as
22 provided in this section: allowable institutional and professional charges for inpatient care,
23 outpatient care, intensive outpatient program services, partial hospitalization treatment, and
24 residential care and treatment:

25 (1) For mental illness treatment:

- 26 a. Licensed psychiatric ~~hospitals~~;
27 hospitals or State psychiatric hospitals accredited by the Joint
28 Commission on the Accreditation of Healthcare Organizations;
29 b. Licensed psychiatric beds in licensed general hospitals;
30 c. Licensed residential treatment facilities that have 24-hour on-site
31 care provided by a registered nurse who is physically located at the
32 facility at all times and that hold current accreditation by a national
33 accrediting body approved by the Plan's mental health case manager;
34 d. Area Mental Health, Developmental Disabilities, and Substance
35 Abuse Authorities or County Programs in accordance with G.S.
36 122C-141;
37 e. Licensed intensive outpatient treatment programs; and
38 f. Licensed partial hospitalization programs.

39 (2) For chemical dependency treatment:

- 40 a. Licensed chemical dependency units in licensed psychiatric
41 ~~hospitals~~; hospitals or in State psychiatric hospitals accredited by the
42 Joint Commission on the Accreditation of Healthcare Organizations;
43 b. Licensed chemical dependency hospitals;
44 c. Licensed chemical dependency treatment facilities;
45 d. Area Mental Health, Developmental Disabilities, and Substance
46 Abuse Authorities or County Programs in accordance with G.S.
47 122C-141;
48 e. Licensed intensive outpatient treatment programs;
49 f. Licensed partial hospitalization programs; and
50 g. Medical detoxification facilities or units."

51 **PART SIX: SALARY-RELATED CONTRIBUTIONS.**

1 **SECTION 6.(a)** Effective for the 2009-2011 fiscal biennium, required employer
2 salary-related contributions for employees whose salaries are paid from department, office,
3 institution, or agency receipts shall be paid from the same source as the source of the
4 employees' salary. If an employee's salary is paid in part from the General Fund or Highway
5 Fund and in part from department, office, institution, or agency receipts, required employer
6 salary-related contributions may be paid from the General Fund or Highway Fund only to the
7 extent of the proportionate part paid from the General Fund or Highway Fund in support of the
8 salary of the employee, and the remainder of the employer's requirements shall be paid from the
9 source that supplies the remainder of the employee's salary. The requirements of this section as
10 to source of payment are also applicable to payments on behalf of the employee for
11 hospital-medical benefits, longevity pay, unemployment compensation, accumulated leave,
12 workers' compensation, severance pay, separation allowances, and applicable disability income
13 benefits.

14 Notwithstanding any other provision of law, an employing unit that is subject to Part
15 3A of Article 3A of Chapter 135 of the General Statutes and that hires or has hired as an
16 employee a retiree that is in receipt of monthly retirement benefits from any retirement system
17 supported in whole or in part by contributions of the State shall enroll the retiree in the active
18 group and pay the cost for the hospital-medical benefits if that retiree is employed in a position
19 that would require the employer to pay hospital-medical benefits if the individual had not been
20 retired.

21 **SECTION 6.(b)** Effective July 1, 2009, the State's employer contribution rates
22 budgeted for retirement and related benefits as percentage of covered salaries for the 2009-2010
23 fiscal year are: (i) eight and fifty-four hundredths percent (8.54%) – Teachers and State
24 Employees; (ii) thirteen and fifty-four hundredths percent (13.54%) – State Law Enforcement
25 Officers; (iii) eleven and eighty-six hundredths percent (11.86%) – University Employees'
26 Optional Retirement System; (iv) eleven and eighty-six hundredths percent (11.86%) –
27 Community College Optional Retirement Program; (v) seventeen and seventy-one hundredths
28 percent (17.71%) – Consolidated Judicial Retirement System; and (vi) four and fifty
29 hundredths percent (4.50%) – Legislative Retirement System. Each of the foregoing
30 contribution rates includes four and fifty hundredths percent (4.50%) for hospital and medical
31 benefits. The rate for Teachers and State Employees, State Law Enforcement Officers,
32 Community College Optional Retirement Program, and for the University Employees' Optional
33 Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income
34 Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include
35 sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law
36 Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

37 **SECTION 6.(c)** Effective July 1, 2010, the State's employer contribution rates
38 budgeted for retirement and related benefits as percentage of covered salaries for the 2010-2011
39 fiscal year are: (i) eight and fifty-four hundredths percent (8.54%) – Teachers and State
40 Employees; (ii) thirteen and fifty-four hundredths percent (13.54%) – State Law Enforcement
41 Officers; (iii) eleven and eighty-six hundredths percent (11.86%) – University Employees'
42 Optional Retirement System; (iv) eleven and eighty-six hundredths percent (11.86%) –
43 Community College Optional Retirement Program; (v) seventeen and seventy-one hundredths
44 percent (17.71%) – Consolidated Judicial Retirement System; and (vi) four and fifty
45 hundredths percent (4.50%) – Legislative Retirement System. Each of the foregoing
46 contribution rates includes four and fifty hundredths percent (4.50%) for hospital and medical
47 benefits. The rate for Teachers and State Employees, State Law Enforcement Officers,
48 Community College Optional Retirement Program, and for the University Employees' Optional
49 Retirement Program includes fifty-two hundredths percent (0.52%) for the Disability Income
50 Plan. The rates for Teachers and State Employees and State Law Enforcement Officers include

1 sixteen-hundredths percent (0.16%) for the Death Benefits Plan. The rate for State Law
2 Enforcement Officers includes five percent (5%) for Supplemental Retirement Income.

3 **SECTION 6.(d)** Effective July 1, 2009, the maximum annual employer
4 contributions, payable monthly, by the State for each covered employee or retiree for the
5 2009-2010 fiscal year to the State Health Plan for Teachers and State Employees are: (i)
6 Medicare-eligible employees and retirees – three thousand three hundred ninety-six dollars
7 (\$3,396) and (ii) non-Medicare-eligible employees and retirees – four thousand four hundred
8 sixty dollars (\$4,460).

9 **SECTION 6.(e)** Effective July 1, 2010, the maximum annual employer
10 contributions, payable monthly, by the State for each covered employee or retiree for the
11 2010-2011 fiscal year to the State Health Plan for Teachers and State Employees are: (i)
12 Medicare-eligible employees and retirees – three thousand six hundred forty-four dollars
13 (\$3,644) and (ii) non-Medicare-eligible employees and retirees – four thousand seven hundred
14 eighty-six dollars (\$4,786).

15 **PART SEVEN: EFFECTIVE DATE.**

16 **SECTION 7.** Sections 1(b), 1(c), 1(d), 2(c) through (e), 2(g), and 2(h) of this act
17 become effective July 1, 2009. The remainder of this act is effective when it becomes law.